The Village of Northfield

REGULAR COUNCIL MEETING AGENDA

SEPTEMBER 23, 2020, 7:30 p.m. (Via Office Suite HD Video)

Call to Order; Roll Call

Approval of Minutes: September 9, 2020 Regular Council Meeting

Reports of Municipal Officers:

Jesse J. Nehez, Mayor Finance Director, Jennifer Potvin Richard Wasosky, Engineer Brad Bryan, Law Director

Department Heads:

John Zolgus, Police Chief Jason Buss, Fire Chief Jason Walters, Service/Building Superintendent

Reports of Municipal Boards and Commissions:

Alan Hipps, Planning Commission Mayor Nehez, Recreation Board Mayor Nehez, Cemetery Board

Reports of Standing Committees:

Finance, Nick Magistrelli Roads and Public Works. Jennifer Domzalski Health and Welfare, Keith Czerr Wages and Working Conditions, Gary Vojtush Fire and Safety, Renell Noack Buildings and Grounds, Alan Hipps

Legislation:

Resolution No. 2020-38, An Emergency Resolution Authorizing Certain Amendments to the 2020 Appropriation Resolution and/or Transferring Items Already Appropriated in that Resolution (First Reading)

Resolution No. 2020-39, An Emergency Resolution Authorizing the Mayor to Enter into Agreements for Employee Medical, Dental, and Vision Coverage (First Reading)

Old Business; New Business; Announcements

Adjournment

VILLAGE OF NORTHFIELD RESOLUTION NO. 2020-38

AN EMERGENCY RESOLUTION AUTHORIZING CERTAIN AMENDMENTS TO THE 2020 APPROPRIATION RESOLUTION AND/OR TRANSFERRING ITEMS ALREADY APPROPRIATED IN THAT RESOLUTION

WHEREAS, as the result of certain occurrences, information, revenues, and expenditures, amendments to the Year 2020 Appropriation Resolution and/or transfers of items already appropriated in the Appropriation Resolution are desired and required.

NOW, THEREFORE, BE IT RESOLVED by the Council of the Village of Northfield, County of Summit, and State of Ohio:

SECTION 1. That in order to better and properly provide for certain revenues and expenditures during the 2020 calendar year, Council hereby and herein authorizes the amendments to the Year 2020 Appropriation Resolution and transfers of items already appropriated in the Year 2020 Appropriation Resolution in the amounts and to the funds set forth in the attachment hereto that is incorporated herein by reference.

SECTION 2. That all formal actions of this Council concerning and relating to the deliberation and adoption of this Resolution were taken in an open meeting of this Council or any of its committees and/or were in compliance with all legal requirements.

SECTION 3. That this Resolution is hereby declared to be an emergency measure necessary for the public peace, health, and welfare of the residents of the Village of Northfield for the reason that this action is required by state law and is necessary for the operation of the Village government, and that this Resolution shall take immediate effect upon its signature by the Mayor, or upon the expiration of time within which it may be disapproved by the Mayor, or upon its passage after its disapproval by the Mayor, as the case may be, pursuant to Village of Northfield Charter Section 4.11.

IN WITNESS WHEREO	F, we have hereunto set our hands this day of, 2020.
	Nicholas Magistrelli, President Pro-Tem of Council
Approved as to Legal Form.	Jesse J. Nehez, Mayor
	Bradric T. Bryan, Director of Law
do nereby certify that the forego	of Council of the Village of Northfield, Summit County, Ohio, ing Resolution was duly and regularly passed by Council at, 2020.
	Jennifer Potvin, Clerk of Council

VILLAGE OF NORTHFIELD Amendments and Transfer Ordinance 2020

Amendments to Current Appropriation		Amount	2020-3
100.1100.51101 100.1100.51102 100.7150.52110 100.7150.52114	Police FT Salaries Police PT Salaries Medical Insurance OP&F Employer Contribution		
230.1100.52114	OP&F Employer Contribution	\$ (8,813.13)	Police Pension Fund
240.1200.51100 240.1200.51101 240.1200.51111	Fire Chief Salary Fire FT Salaries Social Security	\$ (1,904.35) \$ (16,739.40) \$ (196.78)	Fire Levy Fund
311.4000.41425 311.1100.51101 311.1100.51102 311.1100.52114 311.1200.51100 311.1200.51101 311.1200.51111 311.1200.52114 311.7150.52110	Summit County COVID-19 PSGP Police FT Salaries Police PT Salaries OP&F Employer Contribution Fire Chief Salary Fire FT Salaries Social Security OP&F Employer Contribution Medical Insurance	\$104,528.71 \$ 47,886.87 \$ 5,493.10 \$ 8,813.13 \$ 1,904.35 \$ 16,739.40 \$ 196.78 \$ 4,017.46 \$ 19,477.62	Summit County COVID-19 PSGP Fund
RETURN OF ADVANCES			

<u>From</u> <u>To</u>

TRANSFERS

<u>From</u> <u>To</u>

ADVANCES

<u>From</u> <u>To</u>

VILLAGE OF NORTHFIELD RESOLUTION NO. 2020-39 AN EMERGENCY RESOLUTION AUTHORIZING THE MAYOR TO ENTER INTO AGREEMENTS FOR EMPLOYEE MEDICAL, DENTAL, AND VISION COVERAGE

WHEREAS, the Village's employee medical, dental, and vision coverage expires on October 31, 2020; and

WHEREAS, the Village's health care consultant, Michael Troyan of TMC Employee Benefits Group, has examined options related to the renewal of such coverage and made a recommendation to the Village regarding such coverages.

NOW, THEREFORE, BE IT RESOLVED by the Council of the Village of Northfield, County of Summit, and State of Ohio:

SECTION 1. That Council hereby and herein authorizes the Mayor to enter into agreements with Medical Mutual of Ohio for the provision of employee medical and prescription coverage; Guardian Dental for dental coverage; and Guardian-Davis Vision for vision coverage; for the period from Nov. 1, 2020 through Oct. 31, 2021, pursuant to the plans, rates, and coverage provisions specified in the attachments hereto.

SECTION 2. That all formal actions of this Council concerning and relating to the passage of this Resolution were taken at an open meeting of this Council, and all deliberations of this Council and/or any committees that resulted in those formal actions were taken in meetings open to the public in compliance with the law.

SECTION 3. That this Resolution is hereby declared to be an emergency measure necessary for the public peace, health, and welfare of the residents of the Village of Northfield for the reason that it will assist the Village in attracting and maintaining a quality and healthy work force, and that this Resolution shall take immediate effect upon its signature by the Mayor, or upon the expiration of time within which it may be disapproved by the Mayor, or upon its passage after its disapproval by the Mayor, as the case may be, pursuant to Village of Northfield Charter Section 4.11.

IN WITNESS WHEREOF, we	have hereunto set our hands this day or 220.
	Nicholas Magistrelli, Pres. Pro-Tem of Council
	Jesse J. Nehez, Mayor
Approved as to Legal Form.	
_	Bradric T. Bryan, Director of Law
I, Jennifer Potvin, Clerk of Coun hereby certify that the foregoing Resol meeting held on the day	ncil of the Village of Northfield, Summit County, Ohio, ution was duly and regularly passed by Council at a of, 2020.
	Jennifer Potvin, Clerk of Council
*::	John Moral Ottolia, Ottolia Of Obullell

Village of Northfield 2020 Rate Table

			Current Premium			
		Medical				
Contract Type	# of employees	Premium	Dental Premium	Dental Premium Vision Premium	Total	Monthly Total
Single	5	\$775.55	\$31.37	\$9.06	\$815.98	\$4,079.90
Emp/Spouse	vı	\$1,706.21	\$73.83	\$15.27	\$1,795.31	\$8,976.55
Emp & Child(ren)	ω	\$1,395.95	\$101.19	\$15.56	\$1,512.70	\$4,538.10
Family	16	\$2,326.61	\$143.65	\$24,63	\$2,494.89	\$39,918.24
Totals						\$57,512.79

		R	Renewal Premium			
Contract Type	# of employees	Medical Premium	Dental Premium	Dental Premium Vision Premium	Total	Monthly Total
Single	5	\$905.37	\$31.37	\$9.33	\$946.07	\$4,730.35
Emp/Spouse	5	\$1,991.83	\$73.83	\$15.73	\$2,081.39	\$10,406.95
Emp & Child(ren)	ω	\$1,629.63	\$101.19	\$16.03	\$1,746.85	\$5,240.55
Family	16	\$2,716.09	\$143.65	\$25.37	\$2,885.11	\$46,161.76
Totals						\$66,539.61



Coverage for: Single or Family | Plan Type: PPO



for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost

common terms, such as <u>allowed amount, balance billing, coinsurance, copayment, deductible, provider,</u> or other <u>underlined</u> terms see the Glossary. You can view This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-332-0741. For general definitions of the Glossary at MedMutual.com/SBC or call 800-332-0741 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0/single,\$0/family Network \$250/single,\$500/family Non-Network	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan?</u>	\$1,250/single,\$2,500/family Network \$3,000/single,\$6,000/family Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> until the overall family
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, See MedMutual.com/SBC or call 800-332-0741 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider hefore you get services
Do you need a <u>referral</u> to see a <u>specialist?</u>	No	You can see the specialist you choose without a referral.

	If you have outpatient surgery			MedMutual.com/SBC	prescription drug coverage is available at	More information about		illness or condition			in Jon slave a test			n you visit a neath care provider's office or clinic		Common Medical Event
Physician/surgeon fees (Outpatient)	Facility fee (e.g., ambulatory surgery center)	Specially drugs	Non-preferred brand copay - home delivery Tier 3	Non-preferred brand copay - retail Tier 3	Preferred brand copay - home delivery Tier 2	Preferred brand copay - retail Tier 2	Generic copay - home delivery Tier 1	Generic copay - retail Tier 1	Imaging (CT/PET scans, MRIs)	Diagnostic test (blood work)	Diagnostic test (x-ray)	immunization	Specialist visit	Primary care visit to treat an injury or illness		Services You May Need
10% coinsurance	10% coinsurance	Applicable drug tier copay applies	\$120	\$40	\$60	\$20	\$30	\$10	10% coinsurance	No charge	No charge	\$20 copay/visit	\$20 copay/visit	\$20 copay/visit	Network Provider (You will pay the least)	What Yo
30% coinsurance	30% coinsurance	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	30% coinsurance	30% coinsurance	30% coinsurance	50% <u>coinsurance</u> does not apply to <u>out-of-pocket limit</u>	\$25 copay/visit, 30% coinsurance	\$25 copay/visit, 30% coinsurance	Non-Network Provider (You will pay the most)	ou Will Pay
None	None	None	Covers up to a 90-day supply.	Covers up to a 30-day supply.	Covers up to a 90-day supply.	Covers up to a 30-day supply.	Covers up to a 90-day supply.	Covers up to a 30-day supply.	None	None	None	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	None	None	imporant information	Limitations, Exceptions, & Other

						n you need neip recovering or have other special health			п уоц are pregnant	substance abuse services	ir you need mental nealth, behavioral health, or	R	ir you nave a nospital stay	F		attention		Common Medical Event
Hospice services	Durable medical equipment	Skilled nursing care	Therapy)	Therapy)	Therapy)	Home health care	Childbirth/delivery facility services	services	Office visits	iilpatietit services	Outpatient services	Physician/ surgeon fee (inpatient)	racility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care		Services You May Need
10% coinsurance	10% coinsurance	10% coinsurance	10% coinsurance	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% coinsurance	10% coinsurance	\$20 copay/visit	benefits paid based on o	Benefits paid based on o	10% coinsurance	10% coinsurance	\$35 copay/visit	\$50 copay/visit, 10% coinsurance	\$150 copay/vii	Network Provider (You will pay the least	What
50% coinsurance does not apply to out-of-pocket limit	30% coinsurance	30% coinsurance	30% coinsurance	30% <u>coinsurance</u>	30% coinsurance	50% <u>coinsurance</u> does not apply to <u>out-of-pocket limit</u>	30% coinsurance	30% coinsurance	\$25 copay/visit, 30% coinsurance	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	30% coinsurance	30% coinsurance	\$35 copay/visit, 30% coinsurance	\$50 copay/visit, 30% coinsurance	\$150 copay/visit, 10% coinsurance	Non-Network Provider (You will pay the most)	ou Will Pay
None	None	(100 days per benefit period)	(20 visits per benefit period)	(40 visits per benefit period, combined with Physical Therapy)	(40 visits per benefit period, combined with Occupational Therapy)	None	None	None	Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	None	None	None	None	None	None	None	Important Information	Limitations, Exceptions, & Other

		eve care		Common Medical Event
Children's dental check-up	Children's glasses	Children's eye exam		Services You May Need
Not C	Not C	\$20 copay/visit	Network Provider (You will pay the least)	What Yo
t Covered	Not Covered	30% coinsurance	Non-Network Provider (You will pay the most)	u Will Pay
Excluded Service	Excluded Service	None		Limitations, Exceptions, & Other

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) Children's dental check-up Cosmetic Surgery Children's glasses **Bariatric Surgery** Acupuncture Infertility Treatment Long-Term Care **Hearing Aids** Dental Care (Adult) Weight Loss Programs Routine Foot Care Routine Eye Care (Adult) Non-emergency care when traveling outside the U.S.

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	Uner Covered Services (Limitations may apply to these services. This isn't a complete list, Plea	
	Limitations may apply to these so	
	nay apply to	
}	these servic	
	es. This isn'	
	t a complete l	
	list. Please so	
,	ee your <u>plan</u>	
•	document.)	

Chiropractic Care

Private-Duty Nursing

x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596 your state insurance department at 800-686-1526 and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

department at 800-686-1526 or your plan at 800-332-0741. Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your state insurance grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace

costs may be lower. The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your To see examples of how this plan might cover costs for sample medical situations, see the next section-

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles, copayments</u> and note these coverage examples are based on self-only coverage. coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please

Peg is having a baby (9 months of in-network pre-natal care and a hospital delivery) The plan's overall deductible Specialist copay Hospital (facility) coinsurance	are and a \$0 \$20 10%	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) The plan's overall deductible Specialist copay Hospital (facility) coinsurance	\$0 \$20	Mia's Simple Fracture (in-network emergency room visit and follow up care) The plan's overall deductible Specialist copay Hospital (facility) coinsurance
This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)	s like: d work)	This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)	isease	This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)
Total Example Cost	\$12,800	Total Example Cost \$7,400	8	Total Example Cost
In this example, Peg would pay:		In this example, Joe would pay:		in this example. Mia would pay:
Cost Sharing		Cost Sharing		Cost Sharing
Deductibles	\$0	Deductibles \$0	ö	Deductibles
Copayments	\$50	Copayments \$900	ŏ	Copayments
Coinsurance	\$1,200	Coinsurance \$0	ö	Coinsurance
What isn't covered		What isn't covered		What isn't covered
DO104001 1 1101 101144	\$60	Limits or exclusions \$60	ö	Limits or exclusions
Limits or exclusions	\$1,310	The total Joe would pay is \$960	Þ	The total Mia would pay is

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

reduce your costs. For more information about the wellness program, please contact: 800-332-0741.

CMS2003800000196-00485